QUESTIONNAIRE FOR NEW SINUS PATIENTS

NAME _____ DOB _____ MALE/FEMALE _____

TODAY'S DATE _____ PRESENT AGE _____

Who diagnosed you with sinus problems?

_____ Self-diagnosed

_____ Family physician or another health-care professional (nurse, etc.)

What is your most bothersome symptom? Please check <u>one</u> only.

_____ Can't breathe through nose _____ Facial swelling

_____ Headaches/facial pain _____ General tiredness

_____ Runny nose _____ Postnasal drip

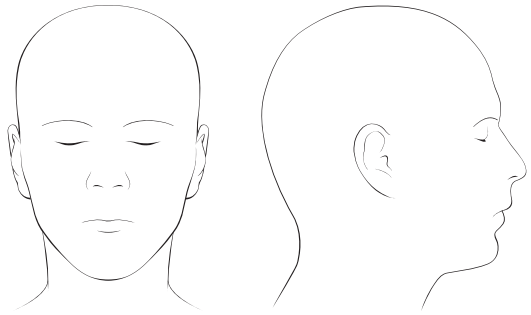
What other symptoms do you have? Check all that apply.

_____ Can't breathe through nose _____ Facial swelling

_____ Headaches/facial pain _____ General tiredness

_____ Runny nose _____ Postnasal drip

If one of your symptoms is headache or facial pain, please indicate on the drawing below where you experience this pain.



How long have you had symptoms of sinusitis?

_____ Less than one month _____ Between one and six months

_____ Six months to two years _____ More than two years

Are your symptoms present

_____ Only occasionally _____ All of the time _____ More than two years _____ Only in certain seasons

What medicines have you tried? (over-the-counter or prescription)

_____ Antibiotics, please list _____

_____ Nonprescription "cold and sinus" preparations

_____ Nasal decongestant sprays or drops (Afrin®, etc.)

_____ Nasal steroid sprays (Flonase, Nasonex, Nasacort®, etc.)

_____ Other medicines

1225 South Gear Avenue • Mercy Plaza, Suite 255 • West Burlington, Iowa 52655
Phone: (319) 752-2725 • IA/IL Toll Free (888) 455-2725 • www.burlingtonent.com

Which of these has worked the best? _____

_____

Have you had:

_____ Sinus X-rays _____ Sinus CT scans _____ Sinus surgery

Please describe your main symptoms: _____

_____

How long have you had your symptoms? _____

How many sinus infections do you have per year? _____

PLEASE PLACE AN X ON YES OR NO AS IT APPLIES AND FILL IN THE BLANK SPACES.

Yes	**No**	
_____	_____	Do you have nasal congestion or blockage?
_____	_____	Is your congestion or blockage predominantly on one side? If yes, which side? _____ Right _____ Left
_____	_____	Do you have postnasal drainage? (Drainage from the nose toward the back of the throat) If so, is this drainage _____ Clear _____ Thick _____ Yellowish or green
_____	_____	Do you have a frequent runny nose? If so, is this drainage _____ Clear _____ Thick _____ Yellowish or green
_____	_____	Do you have a lot of facial pressure or fullness over your sinuses?
_____	_____	Do you have fullness, pressure or pain when leaning over?
_____	_____	Do you have pain with one side worse than the other? If so, which one? _____ Right _____ Left
_____	_____	Do you have aching or pressure that is a steady or constant ache?
_____	_____	Do you have a pounding-type pain?
_____	_____	Have aspirin or ibuprofen (Motrin, Advil, etc.) ever caused you to have wheezing or rashes?
_____	_____	Have you had a significant nasal trauma that you feel may have caused some of your problem?
_____	_____	Do you use over-the-counter decongestant nasal sprays on a regular basis?
_____	_____	Do you have allergies, such as itching and sneezing, runny eyes or other hay fever–type symptoms?
_____	_____	Do you have asthma?
_____	_____	Does your nose react or is it sensitive to _____ Chemicals _____ Hair spray _____ Perfumes _____ Temperature changes
_____	_____	Are you exposed to a lot of chemicals or irritants at or outside work?
_____	_____	Do you have headaches that are directly related to your symptoms?
_____	_____	Do you get hoarseness when you have nasal or sinus symptoms?
_____	_____	Do you have a sore throat with your nasal or sinus symptoms?
_____	_____	Do you have wheezing or asthma attacks with your nasal or sinus symptoms?
_____	_____	Do your nasal or sinus symptoms improve significantly when you are on antibiotics?
_____	_____	Have prescription or over-the-counter medical treatments helped you in any way?
_____	_____	If so, which medications have helped? _____
_____	_____	Have you ever had sinus surgery? If yes, please describe: _____

_____